

# Grant Parish School Board

Pupil Appraisal  
PO Box 208  
Colfax, LA 71417

Telephone (318) 627-3274  
Fax (318) 627-3360

DATE: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

Dear Parent / Guardian:

As you know, your child is eligible to receive Physical and/or Occupational Therapy service in accordance with their current evaluation. This therapy will emphasize motor development and self-help skills so they relate to the child's educational needs. State Law requires that we have current doctor's referral for treatment in order for your child to receive therapy. So that your child may participate, both you and the doctor must sign. Please complete and email this form to Peggy Brunson, Pupil Appraisal Secretary at [pbrunson@gpsb.org](mailto:pbrunson@gpsb.org) or mail to Grant Parish School Board, Special Education Services, PO Box 208, Colfax, LA 71417, Attention: Peggy Brunson

Thank you,

Denise Young, Supervisor  
Special Education Services

\_\_\_\_\_  
Beth Henderson, PT  
Grant Parish School Board

\_\_\_\_\_  
Angie Gauthier, LOTR  
Grant Parish School Board

TO BE COMPLETED BY PHYSICIAN:

I am referring \_\_\_\_\_, for evaluation and treatment by the Physical and/or Occupational Therapist through their school program.

PERTINENT MEDICAL DIAGNOSIS OR INFORMATION: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

To be completed by Physical and/or Occupational Therapist:

The Physical and/or Occupational Therapist requests the doctor's referral to improve the student's functioning in:

Visual-Perceptual/Motor Skills, Eye/Hand Coordination

Therapeutic Exercises \_\_\_\_\_

Gross Motor Development

Fine Motor Development

Self-Help Skills

Gait Training

Other: (Explain) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian MUST sign